DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

January 14, 2011

Mr. Nevelle Wise, Acting Commissioner
Cabinet for Health and Family Services
Department for Medicaid Services
275 East Main Street, 6W-A
Frankfort, Kentucky 40620-0001

RE: Kentucky Title XIX State Plan Amendment, Transmittal 07-008

Dear Mr.Wise:

We have reviewed the proposed amendment to the Kentucky Medicaid State Plan that was submitted under transmittal number 07-008 and received in the Regional Office on September 29, 2009. This amendment's stated purpose is to amend the payment methodology for the Reimbursement Plan of Kentucky's County Health Departments.

Based on the information provided, we are now ready to approve Medicaid State Plan Amendment 07-008. The effective date of this amendment is October 1, 2007. We are enclosing the approved form HCFA-179 and approved plan pages.

Should you have questions or need any further assistance, please contact Donald Graves at (919)-828-2999 or Laura Killebrew at (404) 562-0151.

Sincerely,

Jackie Glaze

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 07-008

2. STATE: Kentucky

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2007

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 C.F.R. 440.100, 447.200-205, 42 U.S.C. 1396a-d

7. FEDERAL BUDGET IMPACT:
a. FFY 2008 save $5,500,000
b. FFY 2009 save $5,500,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B pages 20.6 and 20.7

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Same

10. SUBJECT OF AMENDMENT:
This plan amendment increases the upper payment limit per dental procedure for recipient's under age twenty-one (21). The upper limit increase will apply to all dental procedure codes, except dental procedure codes D2951, D0150, D0140, D0330, D1520, D1525.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED: Review delegated to Commissioner, Department for Medicaid Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Shawn Crouch by Cami Bandy

13. TYPED NAME: Shawn M. Crouch

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: December 7, 2007

16. RETURN TO:
Department for Medicaid Services
275 East Main Street 6W-A
Frankfort, Kentucky 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 12/14/07

18. DATE APPROVED: 01/07/11

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 10/01/07

20. SIGNATURE OF REGIONAL OFFICIAL:
Jackie Glaze

21. TYPED NAME: Jackie Glaze

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health Opns

23. REMARKS:

Approved with following changes as authorized by State Agency on email dated 12/13/10:

Block # 7a Changed to read: 7a FFY 2010 cost $5,500,000 and 7b FFY 2011 cost $5,500,000.

FORM HCFA-179 (07-92)

III. Dental Services

A. Definitions.

For purposes of determination of payment usual and customary actual billed charge refers to the uniform amount the individual dentist charges in the majority of cases for a specific dental procedure or service.

"Dental School Faculty Dentist" is a dentist who is employed by a state-supported school of dentistry.

B. Reimbursement for Outpatient and Inpatient Services.

(1) The department shall reimburse participating dentists for covered services provided to eligible Medicaid recipients at the dentist's actual billed charge not to exceed the fixed upper limit per procedure established by the department.

(2) With the exceptions specified in section (3), (4), (5), and (8) the upper payment limit per procedure shall be established by increasing the limit in effect on 9/30/00 by 32.78%, rounded to the nearest dollar. This rate of increase is based upon an allocation of funds by the 2000 Kentucky General Assembly and a comparison to rates of other states based upon a survey of Dental Fees by the American Dental Association. The DMS fee schedule rate was set as of October 31, 2008 and is effective for services provided on or after that date. All rates are published on the DMS website http://www.chfs.ky.gov/dms/fee.htm.

(3) If an upper payment limit is not established for a covered dental service in accordance with (2) above, the department shall establish an upper limit by the following:

a. The state will obtain no less than three (3) rates from other sources such as Medicare, Workmen's Compensation, private insurers or three (3) high volume Medicaid providers:
b. An average limit based upon these rates will be calculated; and
c. The calculated limit will be compared to rates for similar procedures to assure consistency with reimbursement for comparable services.

(4) The following reimbursement shall apply:

a. Orthodontic Consultation, $112.00, except that a fixed fee of $56.00 shall be paid if:

1. The provider is referring a recipient to a medical specialist;
2. The prior authorization for orthodontic services is not approved; or
3. A request for prior authorization for orthodontic services is not made.

b. Prior authorized early phase orthodontic services for moderately severe disabling malocclusions, $1,367 for orthodontists and $1,234 for general dentists..

c. Prior authorized orthodontic services for moderately severe disabling malocclusions, *$1,825* for orthodontists and $1,649 for general dentists.

d. Prior authorized orthodontic services for severe disabling malocciusions, $2,754 for orthodontists and $2,455 for general dentists.

e. Prior authorized services for Temporomandinbular Joint (TMJ) therapy, an assessed rate per service not to exceed $424.

(5) This reimbursement methodology does not apply to oral surgeons' services that are included within the scope of their licenses. Those services are reimbursed in accordance with the reimbursement methodology for physician services.

(6) Medicaid reimbursement shall be made for medically necessary dental services provided in an inpatient or outpatient setting if:

a. The recipient has a physical, mental, or behavioral condition that would jeopardize the recipient's health and safety if provided in a dentist's office; and

b. In accordance with generally accepted standards of good dental practice, the dental service would customarily be provided in an inpatient or outpatient hospital setting due to the recipient's physical, mental, or behavioral condition.

(7) Supplemental payments will be made in addition to payments otherwise provided under the state plan to practice plans whose dentists qualify for such payments under the criteria outlined below in Part (a) of this section. The payment methodology for establishing and making the supplemental payments is provided below in Parts (b) and (c) of this section.

a. To qualify for a supplemental payment under this section, dentists in the practice plan must meet the following criteria:
i. Be Kentucky licensed dentists;
ii. Be enrolled as Kentucky Medicaid providers; and
iii.Be members of a practice plan under contract to provide professional services at a state-owned academic medical center as determined by the Department.

b. For practice plans qualifying under Part (a) of this section, a supplemental payment will be made. The payment amount will be equal to the difference between Medicaid payments otherwise made to these practice plans and the average rate paid for the services by commercial insurers. The average commercial rates are determined by:
i. Calculating a commercial payment to charge ratio for all services paid to the eligible providers by commercial insurers using the providers' claims-specific data from the most currently available fiscal year;
ii. Multiplying the Medicaid charges by the commercial payment to charge ratio to establish the estimated commercial payments to be made for these services; and
iii. Subtracting the interim Medicaid payments already made for these services to establish the supplemental payment amount.

c. Practice plans eligible under Part (a) of this section will be paid on an interim claims-specific basis through the Department's claims processing system using the methodology outlined elsewhere in this state plan. The supplemental payment, which represents final payment for services, will be made on a quarterly basis or as determined by the Department.

(8) The upper payment limit per procedure for a recipient under age twenty-one (21) shall be established by increasing the limit in effect on 9/30/07 by 30%, rounded to the nearest dollar. The 30% limit increase applied to all dental procedure codes, except dental procedure codes D2951, D0150, D0140, D0330, D1520, D1525, shall not be adjusted from the limit in effect on 9/30/07. The DMS fee schedule rate was set as of October 31, 2008 and is effective for services provided on or after that date. All rates are published on the DMS website http://www.chfs.ky.gov/dms/fee.htm